**Coopersburg Family Practice Dr. Douglas C. Shoenberger PC**

Patient Name: DOB:

As our patient, we may need to communicate with you when you are not in the practice. To assure your privacy, we would like you to indicate your preferred method for us to communicate medical information to you and/or to others involved in your care. Please note that an “***appointment reminder***” is not classified as medical information.

**PLEASE INDICATE YOUR COMMUNICATION PREFERENCES BELOW:**

* I give permission to **leave medical information** pertaining **to me, my dependent or child**, at the numbers listed below:

|  |  |  |  |
| --- | --- | --- | --- |
| **Method** | **Yes** | **No** | **Phone #**  |
| Home (Answering Machine) |  |  |  |
| Cell Phone |  |  |  |
| Work Phone |  |  |  |
| Other |  |  |  |

**Without specific permission**, we will **not** release any medical information to anyone other than you. In some cases you may wish for another person to have access to your medical information. Please identify those individuals and their relationship to you (i.e.: spouse, parent, son, daughter, partner, etc.):

* Do ***not release medical information*** to anyone other than myself.
* I give ***permission to release medical information*** pertaining to me to the individuals listed below:

|  |  |  |
| --- | --- | --- |
| **Name** | **Relationship (i.e. spouse, parent, son, daughter, etc.)** | **Phone #** |
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| **Comments:** |

I assume the responsibility to inform the practice of changes in my phone number(s) or my preferences or to revoke this specific medical information authorization at any time.

Signature: Date:

Printed Name: